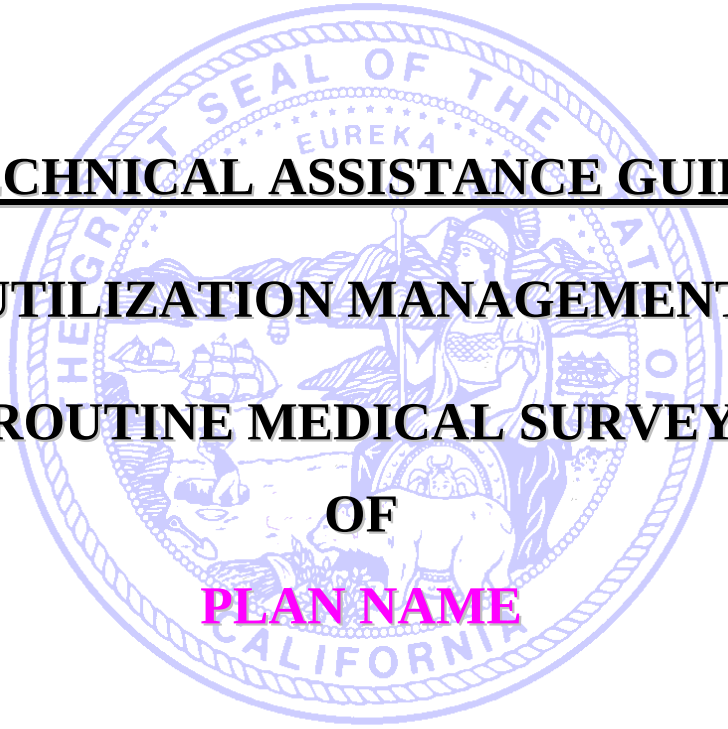
DEPARTMENT OF MANAGED HEALTH CARE
DIVISION OF PLAN SURVEYS

1115 WAIVER SURVEY



TECHNICAL ASSISTANCE GUIDE

UTILIZATION MANAGEMENT

ROUTINE MEDICAL SURVEY

OF

PLAN NAME

DATE OF SURVEY:

PLAN COPY

Issuance of this December 12, 2011 Technical Assistance Guide renders all other versions obsolete.

1115 WAIVER UTILIZATION MANAGEMENT (UM) TAG

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UTILIZATION MANAGEMENT (UM) REQUIREMENTS

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DHCS Two-Plan and GMC Boilerplate Contracts – Exhibit A, Attachment 1 – Organization and Administration of the Plan

6. Medical Director

Contractor shall maintain a full time physician as medical director pursuant to Title 22 CCR Section 53857 whose responsibilities shall include, but not be limited to, the following:

A. Ensuring that medical decisions are:
   1) Rendered by qualified medical personnel.
   2) Are not influenced by fiscal or administrative management considerations.
B. Ensuring that the medical care provided meets the standards for acceptable medical care.
C. Ensuring that medical protocols and rules of conduct for plan medical personnel are followed.
D. Developing and implementing medical policy.
E. Resolving grievances related to medical quality of care.
F. Direct involvement in the implementation of Quality Improvement activities.
G. Actively participating in the functioning of the plan grievance procedures.

DHCS Two-Plan and GMC Boilerplate Contracts – Exhibit A, Attachment 5 – Utilization Management

1. Utilization Management (UM) Program - Contractor shall develop, implement, and continuously update and improve, a Utilization Management (UM) program that ensures appropriate processes are used to review and approve the provision of Medically Necessary Covered Services. Contractor is responsible to ensure that the UM program includes:

A. Qualified staff responsible for the UM program.

C. Allowances for a second opinion from a qualified health professional at no cost to the Member.

D. Established criteria for approving, modifying, deferring, or denying requested services. D. Contractor shall utilize evaluation criteria and standards to approve, modify, defer, or deny services. Contractor shall document the manner in which providers are involved in the development and or adoption of specific criteria used by the Contractor.

2. Pre-Authorizations and Review Procedures - Contractor shall ensure that its pre-authorization, concurrent review and retrospective review procedures meet the following minimum requirements:

C. There is a set of written criteria or guidelines for Utilization Review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated.

CA Health and Safety Code section 1363.5

(a) A plan shall disclose or provide for the disclosure to the director and to network providers the process the plan, its contracting provider groups, or any entity with which the plan contracts for services that include utilization review or utilization management functions, uses to authorize, modify, or deny health care services under the benefits provided by the plan, including coverage for sub-acute care, transitional inpatient care, or care provided in skilled nursing facilities. A plan shall also disclose those processes to enrollees or persons designated by an enrollee, or to any other person or organization, upon request. The disclosure to the director shall include the policies, procedures, and the description of the process that are filed with the director pursuant to subdivision (b) of Section 1367.01.

(b) The criteria or guidelines used by plans, or any entities with which plans contract for services that include utilization review or utilization management functions, to determine whether to authorize, modify, or deny health care services shall:

(1) Be developed with involvement from actively practicing health care providers.

(2) Be consistent with sound clinical principles and processes.

(3) Be evaluated, and updated if necessary, at least annually.

(4) If used as the basis of a decision to modify, delay, or deny services in a specified case under review, be disclosed to the provider and the enrollee in that specified case.

(5) Be available to the public upon request. A plan shall only be required to disclose the criteria or guidelines for the specific procedures or conditions requested. A plan may charge reasonable fees to cover administrative expenses related to disclosing criteria or guidelines pursuant to this paragraph, limited to copying and postage costs. The plan may also make the criteria or guidelines available through electronic communication means.

(c) The disclosure required by paragraph (5) of subdivision (b) shall be accompanied by the following notice: "The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract."

CA Health and Safety Code sections 1367.01(b), (c), (f) and (i)

(b) A health care service plan that is subject to this section shall have written policies and procedures establishing the process by which the plan prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers of health care services for plan enrollees. These policies and procedures shall ensure that decisions based on the medical necessity of proposed health care services are consistent with criteria or guidelines that are supported by clinical principles and processes. These criteria and guidelines shall be developed pursuant to section 1363.5. These policies and procedures, and a description of the process by which the plan reviews and approves, modifies, delays or denies requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, shall be filed with the director for review and approval, and shall be disclosed by the plan to providers and enrollees upon request, and by the plan to the public upon request.

(c) A health care service plan subject to Section 1367.01, shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued to pursuant Section 2050 of the Business and Professions Code or pursuant to Osteopathic Act, or if the plan

is a specialized health care service plan, a clinical director with California licensure in a clinical area appropriate to the type of care provided by the specialized health care service plan. The medical director or clinical director shall ensure that the process by which the plan reviews and approves, modifies, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, complies with the requirements of this section.
(f) The criteria and guidelines used by the health care service plan to determine whether to approve, modify or deny requests by providers prior to, retrospectively, or concurrent with, the provision of health car services to enrollees shall be consistent with clinical principles and processes. These criteria and guidelines shall be developed pursuant to the requirements in Section 1363.5
(i) A health care service plan subject to this section shall maintain telephone access for providers to request authorization for health care services.

28 CCR 1300.70(b)(2)(H)
(b) Quality Assurance Program Structure and Requirements
(2) Program Requirements.
(H) A plan that has capitation or risk-sharing contracts must:
(1) Ensure that each contracting provider has the administrative and financial capacity to meet its contractual obligations; the plan shall have systems in place to monitor QA functions.
(2) Have a mechanism to detect and correct under-service by an at-risk provider (as determined by its patient mix), including possible under utilization of specialist services and preventive health care services.

28 CCR 1300.70(c)
(c) In addition to the internal quality of care review system, a plan shall design and implement reasonable procedures for continuously reviewing the performance of health care personnel, and the utilization of services and facilities, and cost. The reasonableness of the procedures and the adequacy of the implementation thereof shall be demonstrated to the Department.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Medical Director and/or senior Physician responsible for utilization management and/or oversight of enrollment of SPD enrollees
- Utilization Management Director
- Staff assigned to oversee SPD enrollees, including case managers, provider relations staff for medical groups/ IPAs handling high volume of SPD enrollees, etc.

DOCUMENT(S) TO BE REVIEWED

- Policies recently revised to accommodate SPD requirements, e.g., UM policies and procedures, including org charts and committee descriptions, committee membership (A UM Program description may be substituted or in addition to policies and procedures)
- UM policies and procedures and/or Program document outlining development and approval of UM criteria and/or prior authorization list.
- Job Description of the Medical Director responsible for ensuring the UM Process complies with section 1367.01
- UM Committee minutes, list of committee members and medical specialties that sit on and/or consult to the committee

UM-001 - Key Element 1

1. The Plan has utilization management policies and procedures.
DHCS Two-Plan and GMC Boilerplate Contracts – Exhibit A, Attachment 1 – Organization and Administration of the Plan, Item 6 (A) through (G); Attachment 5 – Utilization Management, Item 1 (A), (C), and (D); Item 2 (C); CA Health and Safety Code section 1363.5; CA Health and Safety Code sections 1367.01(b) and (f)

Assessment Questions	Yes	No	N/A
1.1 Do policies and procedures describe the process by which the Plan reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers of health care services for Plan enrollees?			
1.2 Do policies and procedures include utilization review processes such as prospective review, concurrent review?			
1.3 Do the Plan's UM policies and procedures provide for a second opinion as no cost to the enrollee?			

UM-001 - Key Element 2

2. A designated Medical Director is responsible for the oversight of the UM process and holds an unrestricted license to practice medicine in California.
DHCS Two-Plan and GMC Boilerplate Contracts – Exhibit A, Attachment 1 – Organization and Administration of the Plan, Item 6 (A) through (G); CA Health and Safety Code section 1367.01(c)

Assessment Questions	Yes	No	N/A
2.1 Is a Medical Director (Physician) designated to provide clinical direction to the UM Program and ensure compliance with the requirements of the DHCS contract and KKA Section 1367.01?			

Assessment Questions	Yes	No	N/A
2.2 Does the designated individual hold a current unrestricted license to practice medicine in California? (KKA only)			
2.3 Is there evidence that the Medical Director is substantially involved in UM Program operations through significant time devoted to UM activities, clinical oversight and guidance to UM staff?			

UM-001 - Key Element 3

3. The Plan develops UM criteria consistent with acceptable standards and evaluates them annually.
DHCS Two-Plan and GMC Boilerplate Contracts – Exhibit A, Attachment 1 – Organizational and Administration of the Plan, Item 6 (B), (C), and (D); Attachment 5 – Utilization Management, Item 1 (C) and (D), Item 2 (C); CA Health and Safety Code sections 1363.5(a) and (b); CA Health and Safety Code section 1367.01(f)

Assessment Questions	Yes	No	N/A
3.1 Does the Plan utilize criteria/guidelines when determining the medical necessity of requested health care services?			
3.2 Are criteria/guidelines developed with involvement from actively practicing health care providers whose patient mix is primarily the SPD population?			
3.3 Does the Plan conduct an annual review and update of UM criteria/guidelines (or more frequently if needed)?			
3.4 Does the Plan communicate clinical practice guidelines to primary care providers and specialty providers, as appropriate (e.g., via a Provider Manual, a Provider Web site, etc.)?			
3.5 Is there supporting documentation to confirm the criteria/guidelines are consistent with accepted standards of practice (for example, adopted by reputable Physician organizations, consistent with national standards, utilized by Federal agencies)?			
3.6 Can the Plan demonstrate mechanisms to ensure that UM criteria and guidelines are followed?			

End of Requirement UM-001: The Health Plan develops, implements, and maintains a Utilization Management Program

Requirement UM-002: The Health Plan has mechanisms for managing and detecting over- and under-utilization of services

STATUTORY/REGULATORY CITATION(S)

DHCS Two-Plan and GMC Boilerplate Contracts – Exhibit A, Attachment 4 – Quality Improvement System

9. External Quality Review Requirements

At least annually or as designated by DHCS, DHCS shall arrange for an external quality of care review of the Contractor by an entity qualified to conduct such reviews in accordance with Title 22 CCR Section 53860 (d) and Title 42, USC Section 1396u-2(c)(2). Contractor shall cooperate with and assist the External Quality Review Organization (EQRO) designated by the State in the conduct of this review.

B. Under/Over-Utilization Monitoring

In addition to the EAS performance measures, Contractor shall submit to an audit of, and report rates for, an Under/Over-Utilization Monitoring Measure Set based upon selected HEDIS Use of Service measures or any other standardized or DHCS-developed utilization measures selected by DHCS. These measures may be audited as part of the EAS/HEDIS Compliance Audit and these rates shall be submitted with the EAS audited rates or separately as directed by DHCS. DHCS will bear the costs associated with the Compliance Audit as performed by the contracted EQRO. The measures selected for inclusion in the set will be chosen by DHCS on an annual basis. By August 1 of each year, DHCS will notify Contractors of the HEDIS and other EAS performance measures selected for inclusion in the following year's Utilization Monitoring measure set.

DHCS Two-Plan and GMC Boilerplate Contracts – Exhibit A, Attachment 5 – Utilization Management

1. Utilization Management (UM) Program - Contractor shall develop, implement, and continuously update and improve, a UM program that ensures appropriate processes are used to review and approve the provision of Medically Necessary Covered Services. Contractor is responsible to ensure that the UM program includes:

B. The separation of medical decisions from fiscal and administrative management to assure those medical decisions will not be unduly influenced by fiscal and administrative management.

F. An established specialty referral system to track and monitor referrals requiring prior authorization through the Contractor. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals. This specialty referral system should include non-contracting providers.

G. The integration of UM activities into the Quality Improvement System (QIS), including a process to integrate reports on review of the number and types of appeals, denials, deferrals, and modifications to the appropriate QIS staff.

H. Procedures for continuously reviewing the performance of health care personnel, the utilization of services and facilities, and cost.

4. Review of Utilization Data – Contractor shall include within the UM program mechanisms to detect both under- and over-utilization of health care services. Contractor's internal reporting mechanisms used to detect Member utilization patterns shall be reported to DHCS upon request.

CA Health and Safety Code section 1367(g)
The Plan shall have the organizational and administrative capacity to provider services to subscribers and enrollees. The plan shall be able to demonstrate to the department that medical decision are rendered by qualified medical providers, unhindered by fiscal and administrative management.

CA Health and Safety Code section 1367.01(j)
A health care service Plan subject to this section that reviews requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall establish, as part of the quality assurance program required by Section 1370, a process by which the Plan's compliance with this section is assessed and evaluated. The process shall include provisions for evaluation of complaints, assessment of trends, implementation of actions to correct identified problems, mechanisms to communicate actions and results to the appropriate health Plan employees and contracting providers, and provisions for evaluation of any corrective action Plan and measurements of performance.

28 CCR 1300.70(a)(1)
(a) Intent and Regulatory Purpose.
(1) The QA program must be directed by providers and must document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.

28 CCR 1300.70(b)(2)(G)(5)
(b) Quality Assurance Program Structure and Requirements.
(2) Program Requirements. In order to meet these obligations each plan's QA program shall meet all of the following requirements:
(G) Medical groups or other provider entities may have active quality assurance programs which the plan may use. In all instances, however, the plan must retain responsibility for reviewing the overall quality of care delivered to plan enrollees. If QA activities are delegated to a participating provider to ensure that each provider has the capability to perform effective quality assurance activities, the plan must do the following:
(5) Ensure that for each provider the quality assurance/utilization review mechanism will encompass provider referral and specialist care patterns of practice, including an assessment of timely access to specialists, ancillary support services, and appropriate preventive health services based on reasonable standards established by the Plan and/or delegated providers.

28 CCR 1300.70(b)(2)(H)
(b) Quality Assurance Program Structure and Requirements.

(2) Program Requirements.
In order to meet these obligations each plan's QA program shall meet all of the following requirements:
(H) A plan that has capitation or risk-sharing contracts must:
(1) Ensure that each contracting provider has the administrative and financial capacity to meet its contractual obligations; the plan shall have systems in place to monitor QA functions.
(2) Have a mechanism to detect and correct under-service by an at-risk provider (as determined by its patient mix), including possible under utilization of specialist services and preventive health care services.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for UM activities described above, for example:

- UM Director
- QI Director
- Medical Director

DOCUMENT(S) TO BE REVIEWED

- Policies and procedures for UM regarding separation of medical decisions from fiscal management.
- Policies and procedures for Health Plan oversight and review of encounter data to detect Provider Group under- and over-utilization.
- Utilization standards for preventive health care, screening, pharmacy, access to specialty referral, or other standards the Plan uses to determine over- and under-utilization
- UM or QI Annual Work Plan
- External Accountability Set (EAS) Performance Measures reports, utilization trending reports and performance measures, and QI/UM Committee Minutes reflecting review and discussion of results
- UM activity summaries
- UM audit Reports
- UM corrective action plans
- Methods utilized to detect and correct over- and under-utilization

UM-002 - Key Element 1:

1. **The Plan has established and implemented a process to assess and evaluate under- and over-utilization of services.**
   DHCS Two-Plan and GMC Boilerplate Contracts – Exhibit A, Attachment 4 – Quality Improvement System, Item 9 (B); Attachment 5 – Utilization Management, Item 1 (B), (G), and (H); Item 4; CA Health and Safety Code section 1367(g); CA Health and Safety Code section 1367.01(j); 28 CCR 1300.70(b)(2)(H)

Assessment Questions	Yes	No	N/A
1.1 Does the Plan systemically and routinely analyze UM data to monitor for potential over- and under-utilization?			
1.2 Does the Plan regularly report the results of over- and under-utilization monitoring activities to the UM and QI Committees and discuss the findings?			
1.3 Does the Plan identify, communicate, and implement corrective actions when potential over- and under-utilization issues are identified?			
1.4 Does the Plan evaluate the effectiveness of any corrective actions to address over- or under-utilization (using performance measures, for example) and make further recommendations to improve utilization issues?			

UM-002 - Key Element 2:

2. The scope of monitoring includes assessment and evaluation of provider referral and specialist care patterns of practice.
DHCS Two-Plan and GMC Boilerplate Contracts – Exhibit A, Attachment 5 – Utilization Management, Item 1 (F); 28 CCR 1300.70(a)(1); 28 CCR 1300.70(b)(2)(G)(5)

Assessment Questions	Yes	No	N/A
2.1 Does the Plan have mechanisms to detect problems in both provider referral and specialist care practice patterns?			
2.2 Does the Plan analyze access to specialist care, ancillary support services, and appropriate preventive health services?			
2.3 Does the Plan identify, communicate, and implement corrective actions when potential access issues are identified in the UM process?			
2.4 Does the Plan evaluate the effectiveness of any corrective actions (using performance measures, for example) and make further recommendations to improve potential access issues?			

End of Requirement UM-002: The Health Plan has mechanisms for managing and detecting over- and under-utilization of services.

Requirement UM-003: The Health Plan utilizes methodologies and processes to handle prior authorizations appropriately while complying with the requirements specified in the contract as well as in State and Federal laws and regulations

STATUTORY/REGULATORY CITATION(S)

DHCS Two-Plan Boilerplate Contract – Exhibit A, Attachment 5 – Utilization Management

2. Pre-Authorizations and Review Procedures - Contractor shall ensure that its pre-authorization, concurrent review and retrospective review procedures meet the following minimum requirements:

A. Decisions to deny or to authorize an amount, duration, or scope that is less than requested shall be made by a qualified health care professional with appropriate clinical expertise in treating the condition and disease.

B. Qualified health care professionals supervise review decisions, including service reductions, and a qualified Physician will review all denials that are made, whole or in part, on the basis of medical necessity. For purposes of this Provision, a qualified Physician or Contractor's Pharmacist may approve, defer, modify, or deny prior authorizations for pharmaceutical services, provided that such determinations are made under the auspices of and pursuant to criteria established by Contractor's medical director, in collaboration with the Pharmacy and Therapeutics Committee (PTC) or its equivalent.

C. There is a set of written criteria or guidelines for utilization review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated.

D. Reasons for decisions are clearly documented.

E. Notification to members regarding denied, deferred, or modified referrals is made as a specified in Exhibit A, Attachment 13, Member Services. There shall be a well publicized appeals procedure for both providers and patients.

F. Decisions and appeals are made in a timely manner and are not unduly delayed for medical conditions requiring time sensitive services.

G. Prior Authorization requirements shall not be applied to Emergency Services, Minor Consent Services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing.

I. Contractor must notify the requesting provider or Member of any decision to deny, approve, modify, or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the provider may be orally or in writing.

3. Timeframes for Medical Authorization -

A. Emergency Care: No prior authorization required, following the reasonable person standard to determine that the presenting complaint might be an emergency.

B. Post-stabilization: Response to request within 30 minutes or the service is deemed approved in accordance with Title 22 CCR Section 53855 (a), or any future amendments thereto.

C. Non-urgent care following an exam in the emergency room: Response to request within 30 minutes or deemed approved.
D. Concurrent review of authorization for treatment regimen already in place: Within five (5) working days or less, consistent with urgency of the Member's medical condition and in accordance with Health and Safety Code Section 1367.01, or any future amendments thereto.
E. Retrospective review: Within 30 calendar days in accordance with Health and Safety Code Section 1367.01, or any future amendments thereto.
F. Pharmaceuticals: 24 hours on all drugs that require prior authorization in accordance with Welfare and Institutions Code, Section 14185 or any future amendments thereto.
G. Routine authorizations: Five (5) working days from receipt of the information reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-network not otherwise exempt from prior authorization) in accordance with Health and Safety Code, Section 1367.01, or any future amendments thereto, but, no longer than 14 calendar days from the receipt of the request. The decision may be deferred and the time limit extended an additional 14 calendar days only where the Member or the Member's provider requests an extension, or the Contractor can provide justification upon request by the State for the need for additional information and how it is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.
H. Expedited Authorizations: For requests in which a provider indicates, or the Contractor determines that, following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited authorization decision and provide notice as expeditiously as the Member's health condition requires and not later than three (3) working days after receipt of the request for services. The Contractor may extend the three (3) working days time period by up to 14 calendar days if the Member requests an extension, or if the Contractor justifies, to the DHCS upon request, a need for additional information and how the extension is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.
I. Hospice inpatient care: 24-hour response.
J. Therapeutic Enteral Formula for Medical Conditions in Infants and Children: Timeframes for medical authorization of Medically Necessary therapeutic enteral formulas for infants and children and the equipment/and supplies necessary for delivery of these special foods are set forth in MMCD Policy Letter 07-016, Welfare and Institutions Code Section 14103.6 and Health and Safety Code Section 1367.01.

DHCS Two-Plan and GMC Boilerplate Contracts – Exhibit A, Attachment 13 – Member Services

2. Grievance System Oversight

Contractor shall implement and maintain procedures as described below to monitor the Member's Grievance system and the expedited review of grievances required under 28 CCR 1300.68 and 1300.68.01 and 22 CCR 53858.

G. Procedure to ensure that the person making the final decision for the proposed resolution of a grievance has not participated in any prior decisions related to the grievance and is a health

care professional with clinical expertise in treating a Member's condition or disease if any of the following apply:

1) A denial based on lack of medical necessity;
2) A grievance regarding denial of expedited resolutions of an appeal; and
3) Any grievance or appeal involving clinical issues.

8. Denial, Deferral, or Modification of Prior Authorization Requests

A. Contractor shall notify Members of a decision to deny, defer, or modify requests for Prior Authorization by providing written notification to Members and/or their authorized representative, regarding any denial, deferral, or modification of a request for approval to provide a health care service. This notification must be provided as specified in 22 CCR Sections 51014.1, 51014.2, 53894, and Health and Safety Code Section 1367.01.

B. Contractor shall ensure that at least 10 days of advanced notice is given to a Member when a Notice of Action results in a termination, suspension, or reduction of previously authorized covered services. The Contractor shall shorten the advanced notice to five (5) days if probable recipient fraud has been verified.

Contractor shall not be required to provide advanced notice of a termination, suspension, reduction of services, or reduction of previously authorized covered services when the following conditions apply:

1) Death of a Member;
2) Member provides a written statement requesting service termination or giving information requiring termination or reduction of services;
3) Member admission into an institution that makes the Member ineligible for further services;
4) Member's address is unknown and mail directed to the Member has no forwarding address;
5) Member has been accepted for Medi-cal services by another local jurisdiction;
6) Member's Primary Care Physician prescribes a change in the level of medical care;
7) An adverse determination made with regard to the preadmission screening requirements for nursing facility admissions on or after January 1, 1989; or
8) Safety or health of individuals in a facility would be endangered, Member's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the Members urgent medical needs, or Member has not resided in the nursing facility for a minimum of 30 days.

C. Contractor shall provide expedited advanced notice to a Member when Contractor or Primary Care Physician indicates that the standard timeframe could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function. Contractor shall ensure an expedited authorization decision and provide an expedited notice as the Member's health condition requires and no later than three (3) working days after receipt of the request for services. Upon approval from DHCS, Contractor may extend the three (3) working day expedited period to 14 calendar days if the enrollee requests an extension, or if

Contractor justifies a need for additional information and that the extension is in the Member's interest.

D. Contractor shall provide for a written notification to the Member and the Member's authorized representative on a standardized form, approved by DHCS, informing the Member of all the following:
   1) The Member's right to, method of obtaining, and time limit for requesting a fair hearing to contest the denial, deferral, or modification action and the decision the Contractor has made, the reason(s) for the action and the specific regulation(s) or plan authorization procedures supporting the action.
   2) The Member's right to represent himself/herself at the State Fair Hearing or to be represented by legal counsel, friend, or other spokesperson.
   3) The name and address of Contractor and the Department of Social Services (DSS) toll-free telephone number for obtaining information on legal service organizations for representation.

E. Contractor shall provide required notification to beneficiaries and their authorized representatives in accordance with the time frames set forth in 22 CCR 51014.1 and 53894. Such notice shall be deposited with the United States Postal Service in time for pick-up no later than the third working day after the decision is made, not to exceed 14 calendar days from receipt of the original request. If the decision is deferred because an extension is requested or justified as explained in Exhibit A, Attachment 5, Provision 3, Contractor shall notify the Member in writing of the deferral of the decision no later than 14 calendar days from the receipt of the original request. If the final decision is to deny or modify the request, Contractor shall provide written notification of the decision to Members no later than 28 calendar days from the receipt of the original request.

   If the decision regarding a prior authorization request is not made within the time frames indicated in Exhibit A, Attachment 5, Provision 3, the decision is considered denied and notice of the denial must be sent to the Member on the date the time frame expires.

DHCS Two-Plan and GMC Boilerplate Contracts – Exhibit A, Attachment 14 – Member Grievance System

4. Notice of Action

A. A Notice of Action (NOA) is a formal letter informing a Member that a medical service has been denied, deferred, or modified. A NOA must include all of the following:
   1) The action that the MCO or its contractor has taken or intents to take;
   2) The reason for the action;
   3) The Member's or provider's right to file an appeal;
   4) The Member's right to request a State Fair Hearing;
   5) Procedures for exercising the Member's rights to appeal or grieve;
   6) Circumstances under which an expedited review is available and how to request it;
   7) The Member's right to have benefits continue pending resolution of the appeal; and
   8) How to request benefits continue.

CA Health and Safety Code section 1363.5(b)(4)
(b) The criteria or guidelines used by Plans, or any entities with which Plans contract for services that include utilization review or utilization management functions, to determine whether to authorize, modify, or deny health care services shall:
(4) If used as the basis of a decision to modify, delay, or deny services in a specified case under review, be disclosed to the provider and the enrollee in that specified case.

CA Health and Safety Code sections 1367.01(d), (e), (f), (g), and (h)(1) through (5)
d) If health plan personnel, or individuals under contract to the plan to review requests by providers, approve the provider's request, pursuant to subdivision (b), the decision shall be communicated to the provider pursuant to subdivision (h).
(e) No individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny, or modify requests for authorization of health care services for an enrollee for reasons of medical necessity. The decision of the physician or other health care professional shall be communicated to the provider and the enrollee pursuant to subdivision (h).
(f) The criteria or guidelines used by the health care service plan to determine whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall be consistent with clinical principles and processes. These criteria and guidelines shall be developed pursuant to the requirements of Section 1363.5.
(g) If the health care service plan requests medical information from providers in order to determine whether to approve, modify, or deny requests for authorization, the plan shall request only the information reasonably necessary to make the determination.
(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, a health care service plan subject to this section shall meet the following requirements:
(1) Decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with the provision of health care services to enrollees that do not meet the requirements for the 72-hour review required by paragraph (2), shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed five business days from the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with current law. For purposes of this section, retrospective reviews shall be for care rendered on or after January 1, 2000.
(2) When the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process, as described in paragraph (1), would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by

providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. Nothing in this section shall be construed to alter the requirements of subdivision (b) of Section 1371.4. Notwithstanding Section 1371.4, the requirements of this division shall be applicable to all health plans and other entities conducting utilization review or utilization management.

(3) Decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees shall be communicated to the requesting provider within 24 hours of the decision. Except for concurrent review decisions pertaining to care that is underway, which shall be communicated to the enrollee's treating provider within 24 hours, decisions resulting in denial, delay, or modification of all or part of the requested health care service shall be communicated to the enrollee in writing within two business days of the decision. In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.

(4) Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall specify the specific health care service approved. Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall be communicated to the enrollee in writing, and to providers initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification. Responses shall also include information as to how the enrollee may file a grievance with the plan pursuant to Section 1368, and in the case of Medi-Cal enrollees, shall explain how to request an administrative hearing and aid paid pending under Sections 51014.1 and 51014.2 of Title 22 of the California Code of Regulations.

(5) If the health care service Plan cannot make a decision to approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2) because the Plan is not in receipt of all of the information reasonably necessary and requested, or because the Plan requires consultation by an expert reviewer, or because the Plan has asked that an additional examination or test be performed upon the enrollee, provided the examination or test is reasonable and consistent with good medical practice, the Plan shall, immediately upon the expiration of the timeframe specified in paragraph (1) or (2) or as soon as the Plan becomes aware that it will not meet the timeframe, whichever occurs first, notify the provider and the enrollee, in writing, that the Plan cannot make a decision to approve, modify, or deny the request for authorization within the required timeframe, and specify the information requested but not

received, or the expert reviewer to be consulted, or the additional examinations or tests required. The Plan shall also notify the provider and enrollee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the Plan, the Plan shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2), whichever applies.

CA Health and Safety Code section 1374.30(i)
(i) No later than January 1, 2001, every health care service Plan shall prominently display in every Plan member handbook or relevant informational brochure, in every Plan contract, on enrollee evidence of coverage forms, on copies of Plan procedures for resolving grievances, on letters of denials issued by either the Plan or its contracting organization, on the grievance forms required under Section 1368, and on all written responses to grievances, information concerning the right of an enrollee to request an independent medical review in cases where the enrollee believes that health care services have been improperly denied, modified, or delayed by the Plan, or by one of its contracting providers.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- UM Director and/or Managers
- Medical Director and/or senior Physician responsible for UM

DOCUMENT(S) TO BE REVIEWED

- UM policies and procedures, including UM decision timeframe requirements, UM criteria, policies regarding denial letters
- Organization charts, committee descriptions and key staff job descriptions of staff involved in UM review
- Sample UM denial, deferral and modification letter templates
- Criteria plan uses to determine medical necessity
- Criteria development, review, revision, distribution and training processes
- Description of treatment authorization processes

UM-003 - Key Element 1

1. **The Plan has written policies and procedures for review and approval, modification, delay, or denial of services (medical necessity denials) and ensures they are consistently applied.**
   DHCS Two-Plan and GMC Boilerplate Contracts– Exhibit A, Attachment 5 – Utilization Management, Item 2 (A), (B), (F), (G), and (I); Attachment 13 – Member Services, Item 2 (G); Attachment 14 – Member Grievance System Item 4 (A); CA Health and Safety Code sections 1367.01(d), (e), (f), (g), and (h)(1) through (5)

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have policies and procedures to ensure that only licensed Physicians or licensed health care professionals (with appropriate clinical expertise in treating the requested condition or disease) make decisions to deny or modify requested services on the basis of medical necessity?			
1.2 Do qualified health care professionals supervise review decisions, including service reductions?			
1.3 Can the Plan demonstrate that decisions are made in a timely manner in accordance with the medical conditions requiring time sensitive services?			
1.4 Can the Plan demonstrate that only licensed physician or health care professional (competent to evaluate clinical issues related to the requested health care services) make decisions to deny or modify requested services on the basis of medical necessity?			

UM-003 - Key Element 2

2. The Plan has established and implemented written policies and procedures regarding the timeliness of UM Decisions and ensures they are consistently applied.
DHCS Two-Plan and GMC Boilerplate Contracts – Exhibit A, Attachment 5 – Utilization Management, Item 2 (A), (B), (F), (G), and (I); Item 3 (A) through (J); Attachment 13 – Member Services, Item 8 (A) through (E); CA Health and Safety Code sections 1367.01(h)(1) through (4);

Assessment Questions	Yes	No	N/A
For prior authorization or concurrent review of treatment already in place, do Health Plan policies dictate decisions must be made in the following timeframes: 2.1 Decisions to approve, modify, or deny requests by providers are made in a timely fashion, not to exceed <u>five business days</u> after the Plan's receipt of the information reasonably necessary to make the determination?			
2.2 Decisions to approve, modify, or deny requests for <u>urgent or expedited</u> referrals and requests the decision does not exceed <u>72 hours (Commercial members) or 3 working days (Medi-Cal SPD members)</u> after the Plan's receipt of the information reasonably necessary and requested by the Plan to make the determination?			
2.3 Can the Plan demonstrate mechanisms (through file audits, reports, or other processes) that the Plan and/or Delegate makes decisions to approve, modify, or deny the request within the required timeframes?			

Assessment Questions	Yes	No	N/A
2.4 For Prescription Drug authorizations, can the Plan demonstrate an ability to ensure that determinations are made within 24 hours on all drugs that require prior authorization?			
2.5 For **Hospice Inpatient Care**, does the Plan make the decision to approve, modify, or deny the request **within 24 hours**?			
2.6 Can the Plan demonstrate that it does not require prior authorization for emergency services?			

UM-003 - Key Element 3:

3. Care shall not be discontinued until a care plan that is appropriate for the medical needs of that patient has been agreed upon by the treating provider.
DHCS Two-Plan and GMC Boilerplate Contracts – Exhibit A, Attachment 5 – Utilization Management, Item 3 (A) through (J); CA Health and Safety Code section 1367.01(h)(3)

Assessment Questions	Yes	No	N/A
3.1 Does the Plan's policy and practice demonstrate that treating providers can readily access the Plan Physician that made the adverse decision?			
3.2 Does the Plan document receipt of agreement by the treating provider?			
3.3 Does the Plan effectively monitor the turn-around time for the Health Plan's physician to respond to the treating provider?			

UM-003 - Key Element 4

4. The Plan has established and implemented guidelines for UM-related communications to providers and enrollees (including content, form, and timeframes).
DHCS Two Plan and GMC Boilerplate Contracts – Exhibit A, Attachment 5 – Utilization Management, Item 2 (D) and (E); Attachment 14 – Member Grievance System, Item 4 (A); CA Health and Safety Code section 1363.5(b)(4); CA Health and Safety Code sections 1367.01(d), (h)(3) and (4); CA Health and Safety Code section 1374.30(i)

Assessment Questions	Yes	No	N/A
Can the Plan demonstrate that it complies with the following (through audit reports, policies and procedures, letter/fax dates and times, etc.): 4.1 Communications regarding decisions to approve requests by providers identify the specific health care service approved?			

Assessment Questions	Yes	No	N/A
4.2 UM decisions to approve, deny, delay, or modify health care services are communicated **to requesting providers** initially by telephone, facsimile, or electronic mail **within 24 hours** of making the decision? `			
4.3 UM decisions to approve, deny, delay, or modify health care services are sent **to enrollees** in writing.			
4.4 Notifications of Action (NOA) provide a clear and concise explanation of the reasons for the Plan's decision to deny, delay, or modify health care services?			
4.5 Notifications of Action (NOA) specify the criteria or guidelines used for the Plan's decision to deny, delay, or modify health care services?			
4.6 Notifications of Action (NOA) specify the clinical reasons for the Plan's decision to deny, delay, or modify health care services?			
4.7 Written communications to a Physician or other health care provider of a denial, delay, or modification of a request include the name of the health care professional responsible for the denial, delay, or modification?			
4.8 Written communications to a Physician or other health care provider of a denial, delay, or modification of a request include the direct telephone number or an extension of the healthcare professional responsible for the denial, delay, or modification to allow ease of contact?			
4.9 Written communications to an enrollee of a denial, delay, or modification of a request include information as to how he / she may file a grievance or appeal to the Plan, and the criteria under which an expedited appeal may be requested?			
4.10 Written communications to an enrollee of a denial, delay, or modification of a request include information as to how he / she may request an independent medical review or State Fair Hearing in cases where the enrollee believes that health care services have been improperly denied, modified, or delayed by the Plan, or by one of its contracting providers?			

UM-003 - Key Element 5

5. The Plan has established and implemented guidelines for communicating to the enrollee and Physician if a UM decision will not be made within 5 business days.
DHCS Two-Plan and GMC Boilerplate Contracts – Exhibit A, Attachment 13 – Member Services, Item 8 (E); CA Health and Safety Code section 1367.01(h)(5)

Assessment Questions	Yes	No	N/A
5.1 Does the Plan have guidelines for communicating with the enrollee and provider in writing if UM decisions do not meet the required timeframes?			
5.2 If the Plan is unable to make a UM decision within the required timeframe, does the Plan notify the provider and enrollee of the anticipated decision date?			

End of Requirement UM-003: The Health Plan utilizes methodologies and processes to handle prior authorizations appropriately while complying with the requirements specified in the contract as well as in State and Federal laws and regulations.

1115 WAIVER UTILIZATION MANAGEMENT (UM) TAG

Requirement UM-004: The Health Plan utilizes methodologies and processes to evaluate utilization management activities of delegated entities

NOTE: In addition, the delegate is subject to and should be assessed against audit requirements referenced in UM 001 – 003.

STATUTORY/REGULATORY CITATION(S)

DHCS Two-Plan and GMC Boilerplate Contracts – Exhibit A, Attachment 1 – Organization and Administration of the Plan

6. Medical Director

Contractor shall maintain a full time physician as medical director pursuant to Title 22 CCR Section 53857 whose responsibilities shall include, but not be limited to, the following:

A. Ensuring that medical decisions are:
   1) Rendered by qualified medical personnel.
   2) Are not influenced by fiscal or administrative management considerations.
B. Ensuring that the medical care provided meets the standards for acceptable medical care.
C. Ensuring that medical protocols and rules of conduct for plan medical personnel are followed.
D. Developing and implementing medical policy.
E. Resolving grievances related to medical quality of care.
F. Direct involvement in the implementation of Quality Improvement activities.
G. Actively participating in the functioning of the plan grievance procedures.

DHCS Two-Plan and GMC Boilerplate Contracts – Exhibit A, Attachment 4 – Quality Improvement System

6. Delegation of Quality Improvement Activities

A. Contractor is accountable for all quality improvement functions and responsibilities (e.g. Utilization Management, Credentialing, and Site Review) that are delegated to subcontractors. If Contractor delegates quality improvement functions, Contractor and delegated entity (subcontractor) shall include in their subcontract, at minimum:
   1) Quality improvement responsibilities, and specific delegated functions and activities of the Contractor and subcontractor.
   2) Contractor's oversight, monitoring, and evaluation processes and subcontractor's agreement to such processes.
   3) Contractor's reporting requirements and approval processes. The agreement shall include subcontractor's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly.
   4) Contractor's actions/remedies if subcontractor's obligations are not met.
B. Contractor shall maintain a system to ensure accountability for delegated quality improvement activities, that at a minimum:
   1) Evaluates subcontractor's ability to perform the delegated activities including an initial review to assure that the subcontractor has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities.

2) Ensures subcontractor meets standards set forth by the Contractor and DHCS.
3) Includes the continuous monitoring, evaluation and approval of the delegated functions...

DHCS Two-Plan and GMC Boilerplate Contracts – Exhibit A, Attachment 5 – Utilization Management

1. Utilization Management Program

Contractor shall develop, implement, and continuously update and improve, a Utilization Management (UM) program that ensures appropriate processes are used to review and approve the provision of Medically Necessary Covered Services. Contractor is responsible to ensure that the UM program includes:

D. Established criteria for approving, modifying, deferring, or denying requested services. Contractor shall utilize evaluation criteria and standards to approve, modify, defer, or deny services. Contractor shall document the manner in which providers are involved in the development and or adoption of specific criteria used by the Contractor.
E. Contractor shall communicate to health care practitioners the procedures and services that require prior authorization and ensure that all contracting health care practitioners are aware of the procedures and timeframes necessary to obtain prior authorization for these services.

5. Delegating UM Activities

Contractor may delegate UM activities. If Contractor delegates these activities, Contractor shall comply with Exhibit A, Attachment 4, Provision 6 – Delegation of Quality Improvement Activities.

CA Health and Safety Code section 1363.5(b)

(b) The criteria or guidelines used by plans, or any entities with which plans contract for services that include utilization review or utilization management functions, to determine whether to authorize, modify, or deny health care services shall:
(1) Be developed with involvement from actively practicing health care providers.
(2) Be consistent with sound clinical principles and processes.
(3) Be evaluated, and updated if necessary, at least annually.
(4) If used as the basis of a decision to modify, delay, or deny services in a specified case under review, be disclosed to the provider and the enrollee in that specified case.
(5) Be available to the public upon request. A plan shall only be required to disclose the criteria or guidelines for the specific procedures or conditions requested. A plan may charge reasonable fees to cover administrative expenses related to disclosing criteria or guidelines pursuant to this paragraph, limited to copying and postage costs. The plan may also make the criteria or guidelines available through electronic communication means.

CA Health and Safety Code sections 1367.01(a), (b), (c), (e), (f), (h), (i) and (j)

(a) A health care service plan and any entity with which it contracts for services that include utilization review or utilization management functions, that prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively or concurrent with the provision of health care services to enrollees, or that delegates these functions to medical groups or

independent practice associations or to other contracting providers, shall comply with this section.
(b) A health care service plan that is subject to this section shall have written policies and procedures establishing the process by which the plan prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers of health care services for plan enrollees. These policies and procedures shall ensure that decisions based on the medical necessity of proposed health care services are consistent with criteria or guidelines that are supported by clinical principles and processes. These criteria and guidelines shall be developed pursuant to Section 1363.5. These policies and procedures, and a description of the process by which the plan reviews and approves, modifies, delays, or denies requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, shall be filed with the director for review and approval, and shall be disclosed by the plan to providers and enrollees upon request, and by the plan to the public upon request.
(c) A health care service plan subject to this section shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 of the Business and Professions Code or pursuant to the Osteopathic Act, or, if the plan is a specialized health care service plan, a clinical director with California licensure in a clinical area appropriate to the type of care provided by the specialized health care service plan. The medical director or clinical director shall ensure that the process by which the plan reviews and approves, modifies, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, complies with the requirements of this section.
(e) No individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny, or modify requests for authorization of health care services for an enrollee for reasons of medical necessity. The decision of the physician or other health care professional shall be communicated to the provider and the enrollee pursuant to subdivision (h).
(f) The criteria or guidelines used by the health care service plan to determine whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall be consistent with clinical principles and processes. These criteria and guidelines shall be developed pursuant to the requirements of Section 1363.5.
(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, a health care service plan subject to this section shall meet the following requirements:
(1) Decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with the provision of health care services to enrollees that do not meet the requirements for the 72-hour review required by paragraph (2), shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed five business days from the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt

of information that is reasonably necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with current law. For purposes of this section, retrospective reviews shall be for care rendered on or after January 1, 2000.
(2) When the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process, as described in paragraph (1), would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. Nothing in this section shall be construed to alter the requirements of subdivision (b) of Section 1371.4. Notwithstanding Section 1371.4, the requirements of this division shall be applicable to all health plans and other entities conducting utilization review or utilization management.
(3) Decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees shall be communicated to the requesting provider within 24 hours of the decision. Except for concurrent review decisions pertaining to care that is underway, which shall be communicated to the enrollee's treating provider within 24 hours, decisions resulting in denial, delay, or modification of all or part of the requested health care service shall be communicated to the enrollee in writing within two business days of the decision. In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.
(4) Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall specify the specific health care service approved. Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall be communicated to the enrollee in writing, and to providers initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification. Responses shall also include information as to how the enrollee may file a grievance with the plan pursuant to Section 1368, and in the case of Medi-Cal enrollees, shall explain how to request an administrative hearing and aid paid pending under Sections 51014.1 and 51014.2 of Title 22 of the California Code of Regulations.
(5) If the health care service plan cannot make a decision to approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2) because the plan is not

in receipt of all of the information reasonably necessary and requested, or because the plan requires consultation by an expert reviewer, or because the plan has asked that an additional examination or test be performed upon the enrollee, provided the examination or test is reasonable and consistent with good medical practice, the plan shall, immediately upon the expiration of the timeframe specified in paragraph (1) or (2) or as soon as the plan becomes aware that it will not meet the timeframe, whichever occurs first, notify the provider and the enrollee, in writing, that the plan cannot make a decision to approve, modify, or deny the request for authorization within the required timeframe, and specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The plan shall also notify the provider and enrollee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the plan, the plan shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2), whichever applies.
(6) If the director determines that a health care service plan has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the director may assess, by order, administrative penalties for each failure. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice to, and an opportunity for a hearing with regard to, the person affected, in accordance with subdivision (a) of Section 1397. The administrative penalties shall not be deemed an exclusive remedy for the director. These penalties shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45.
(i) A health care service plan subject to this section shall maintain telephone access for providers to request authorization for health care services.
(j) A health care service plan subject to this section that reviews requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall establish, as part of the quality assurance program required by Section 1370, a process by which the plan's compliance with this section is assessed and evaluated. The process shall include provisions for evaluation of complaints, assessment of trends, implementation of actions to correct identified problems, mechanisms to communicate actions and results to the appropriate health plan employees and contracting providers, and provisions for evaluation of any corrective action plan and measurements of performance.

28 CCR 1300.70(b)(2)(G)(5)
(b) Quality Assurance Program Structure and Requirements.
(2) Program Requirements.
In order to meet these obligations each plan's QA program shall meet all of the following requirements:
(G) Medical groups or other provider entities may have active quality assurance programs which the plan may use. In all instances, however, the plan must retain responsibility for reviewing the overall quality of care delivered to plan enrollees. If QA activities are delegated to a participating provider to ensure that each provider has the capability to perform effective quality assurance activities, the plan must do the following:
(5) Ensure that for each provider the quality assurance/utilization review mechanism will encompass provider referral and specialist care patterns of practice, including an assessment of

timely access to specialists, ancillary support services, and appropriate preventive health services based on reasonable standards established by the Plan and/or delegated providers.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Medical Director
- UM or QI Director
- Director of government compliance
- Director of delegated entities (or equivalent), if necessary

DOCUMENT(S) TO BE REVIEWED

- Plan to delegate contract or Delegation Agreement
- Materials provided by the Plan to the delegate to delineate responsibilities and monitoring activities
- Delegated entity UM Program description, policies and procedures, and criteria, as applicable
- Plan audit tool and sample audits of delegated entities
- Delegate UM reports
- Minutes of meetings where Plan presents audit findings for delegated entity audit
- Corrective action plans submitted and reviewed as necessary
- Provider service agreement and amendments addenda as applicable

UM-004 - Key Element 1:

1. **Delegation Oversight: The Plan has policies and procedures for monitoring its delegated entities including the methodology and frequency of oversight and the Plan conducts regular oversight of the UM Program for each of its delegated entities for compliance with its established UM standards.**
   DHCS Two-Plan and GMC Boilerplate Contracts – Exhibit A, Attachment 4 – Quality Improvement System, Item 6 (A) and (B); CA Health and Safety Code sections 1367.01(a) and (b)

Assessment Questions	Yes	No	N/A
1.1 Is there a delegation agreement between the Plan and the entity to which the Plan has delegated management (of UM, QI, benefits, etc.) that includes, but is not limited to a description of the delegated services, activities and administrative responsibilities?			

Assessment Questions	Yes	No	N/A
1.2 Does the Plan have policies and procedures for monitoring its delegated entities including methodology and frequency of oversight?			
1.3 Does the Plan conduct regular oversight of the UM Program for each of its delegated entities for compliance with its established UM standards?			

UM-004 - Key Element 2:

2. UM Program: Each delegate has a written description of the UM Program that includes structure, scope, criteria, processes, and policies (as outlined in UM-001), and has a designated Medical Director who is responsible for UM Program oversight.
DHCS Two-Plan and GMC Boilerplate Contracts – Exhibit A, Attachment 1 – Organization and Administration of the Plan, Item 6 (A) through (G); Attachment 4 – Quality Improvement System, Item 6; Attachment 5 – Utilization Management, Item 5; CA Health and Safety Code sections 1367.01(a) through (c), (f), (h), and (j)

Assessment Questions	Yes	No	N/A
2.1 Does the Plan ensure that each delegate has a written description of the UM Program that includes structure, scope, criteria, processes, and policies and is consistent with the Plan's UM Program?			
2.2 Does the Plan ensure that each delegate has a designated Medical Director who holds an unrestricted license to practice medicine in California?			
2.3 Does the Medical Director's position description include substantial responsibility for providing clinical direction and oversight of the UM Program?			
2.4 Has the delegated entity established and implemented policies and procedures regarding approval, modification, delay or denial of services as well as the timeliness of those decisions?			
2.5 Is there evidence that the delegate has developed written UM criteria/guidelines consistent with acceptable standards and perform an annual evaluation and review?			
2.6 Has the delegate established and implemented guidelines for UM-related communications to providers and enrollees (including content, form, and timeframes)?			

End of Requirement UM-004: The Health Plan utilizes methodologies and processes to evaluate utilization management activities of delegated entities.